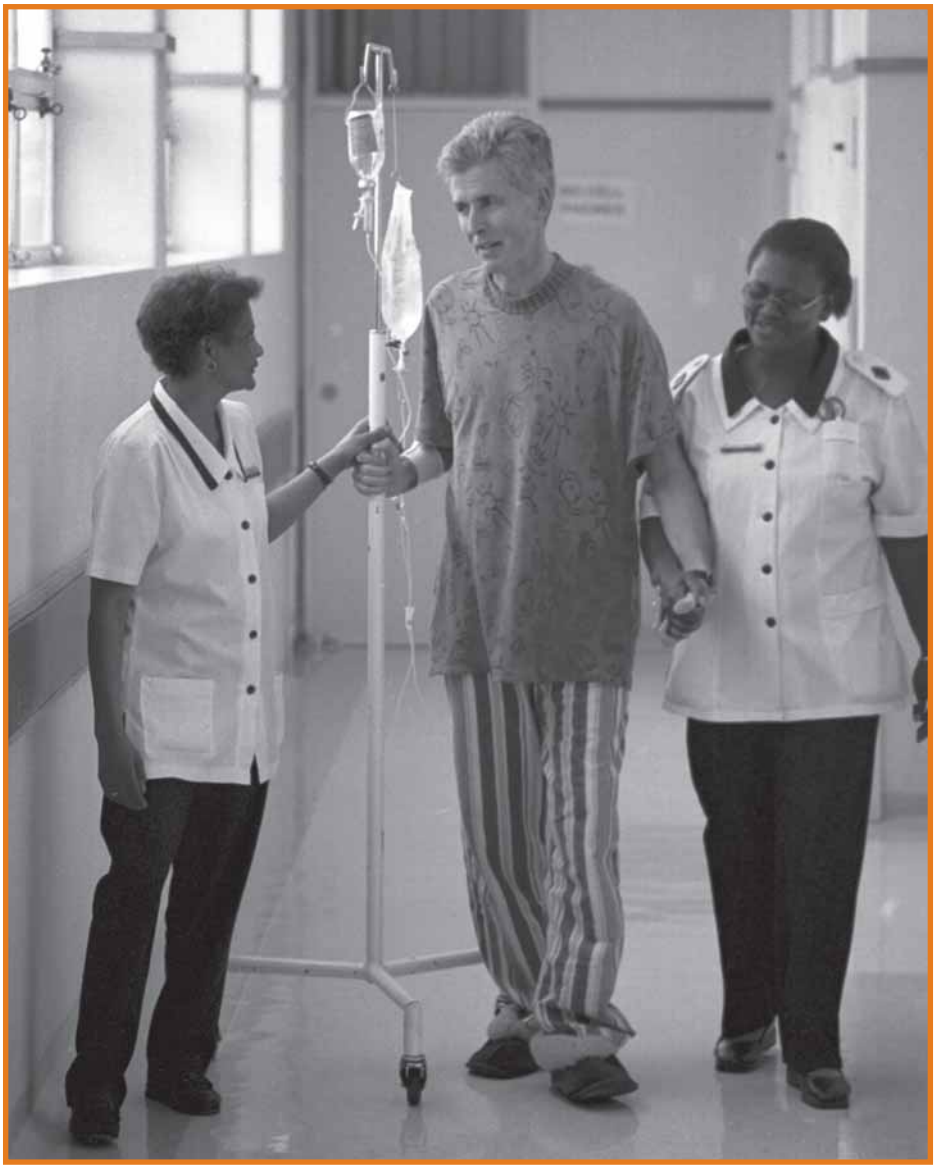
Health care rights

CHAPTER 8



Contents

KEY WORDS

Access	Ability to get, have or use something, eg access to health care.
Adequate	Suitable, sufficient, up to a good enough standard.
Antiretroviral treatment	Drug treatment that fights against HIV by slowing down and controlling the spread of HIV in your body.
Breach	Break or not respect, eg breach your right to give informed consent to have an HIV test.
CD4 count	A measure of the strength of your immune system – CD4 cells are white blood cells that organise the body's response to viruses like HIV.
Comply	Whether or not you obey policy, law and procedure.
Confidentiality	Keeping information about a patient private.
Consent	Permission or agreement.
Constitutionality	Whether or not laws and regulations are in line with the Constitution.
Diagnose	Explain to someone what his/her medical condition is.
Diagnostic	To do with a medical diagnosis or a decision on what illness you have.
Endemic	Found in a local area, or associated with people in this area.
Equitable/Equitably	Handle fairly and reasonably.
Informed consent	Giving permission for a medical procedure or test after receiving full information, including understanding the benefits, possible harm and the choices you have.
Lactating	The period when women produce milk after childbirth.
Legally binding	Law or rule that you must follow.

Living positively	Living healthily with HIV and with a positive state of mind.
Lobbying	Persuading or influencing people in authority, eg to introduce or revise laws.
Marginalised	When some groups are excluded or sidelined.
Negative duty	A duty not to do something or to stop doing something that will affect a person's rights.
Positive duty	A duty to do something that will help realise a person's right to health.
Primary health care	Basic medical care, such as check-ups for children and pregnant woman, and HIV counselling and testing at clinics by doctors and nurses.
Reproductive health	Physical, mental and social well being to do with your reproductive system and all its functions.
Stigma	Negative attitudes, beliefs and feelings about a person, eg because you are living with HIV.
Transmission	To pass on a virus or an illness to another person.
Treatment literacy	Helping people understand how HIV can progress to AIDS, what they can do to protect their health, and why, how and when to take antiretrovirals and other treatments.
Unconstitutional	Not in line with the Constitution.
Unfair discrimination	A policy, law, condition or situation that unfairly disadvantages you, eg because you are a woman, black, lesbian, living with a disability, or living with HIV.
Validly	Whether or not new or existing policies or regulations are allowed under the law.
Violate/Violation	Abusing or not respecting, eg violate your right of access to health.
Voluntarily	By choice and without force.
Vulnerable groups	People that need special protection, eg children, people in detention.

8.1 Why is it important to understand your health rights?

CASE STUDY

SUPPORT AND TREATMENT WHILE LIVING WITH HIV

Francis Tsengwa lives in Site C, Khayelitsha, near Cape Town with her four daughters, Neliswa (19), Zisanda (17), Ntombizodwa (7) and Sandisiwe (3). At the beginning of 2002 her husband, Fani, told her that he was HIV positive and left her for another woman. Francis and her two younger children tested HIV positive soon afterwards and they were all put on antiretroviral (ARV) treatment, as they were living near a day hospital set up by the organisation called Medécins Sans Frontières.

In August 2004, Francis visited a *sangoma*, who told her to stop taking ARVs and to stop giving the drugs to her daughters. Around this time, the social grant (Disability Grant) she received from government was also cancelled. This is because only people living with HIV with a CD4 count lower than 200 qualify for a Disability Grant and Francis's CD4 count had risen to 600 after taking ARVs.

Soon afterwards the children became very ill with diarrhoea. Francis was also kicked out of her house and she had to go and live in a shack in Lwandle. For several months she did not return to the clinic because she was depressed and had no money to travel to the clinic where she would have to wait in a long queue to see the doctor. She had also contracted tuberculosis (TB) and became very ill herself. She could not walk anymore and was so weak that her eldest daughters had to carry her from the bed to the chair.

Meanwhile Zisanda fell pregnant and in 2004 she gave birth to a baby girl at the State hospital. She had to stay in hospital for three days because it was a difficult birth, but she was very happy when her daughter tested negative for HIV. Zisanda takes her daughter to the clinic every six months for a check-up where she has to wait with other mothers in a long queue, often for the whole day.

In the middle of 2005, a friend took Francis and the two youngest daughters back to the clinic. Francis was first put on TB medicine and later on ARVs. The daughters were also put back on ARVs. They have all recovered and are now living positively with HIV. Her doctor informed Francis that she and her youngest children had made a good recovery, and that they have a good chance of staying healthy, as long as they keep on taking ARVs every day.

The doctor, who works at the clinic three times a week, is overworked and complains that she does not have the necessary support staff and medicine to provide the same care that patients would get in town. Some days she works from 8 in the morning until 8 at night.

Information taken and translated from 'Daar is tog 'n môre', by Willemien Brümmer, Die Burger, 30 November 2005

Understanding your health rights will allow you to take steps to advance and protect your rights, and to make the best decisions about your health and the health of your family.

8.2 History and current context

8.2.1 The impact of apartheid

Apartheid laws and policies had a very negative effect on the health of millions of black people in South Africa. Black people were denied adequate housing, water, sanitation and access to schools, hospitals and other medical care. These living conditions caused a poor state of health amongst many black people.

Health services in South Africa were divided according to race, geographic location, and whether they were public or private services. The best services were provided in big cities to white people, who could afford medical aid and could go to private doctors and hospitals. As most black people could not afford private health care services, they had to make use of racist and inaccessible public health services. These apartheid health structures offered very little help to poor, black South Africans when they were ill.

The health system also failed to adequately address the health problems of the poor majority. Most of the money, doctors and equipment were used to address the complicated and expensive health needs of white patients, for example for open-heart transplants (*Baldwin-Ragaven, De Gruchy and London, 1999, 30*).

EXAMPLES

HEALTH PROFESSIONALS UNDER APARTHEID

- *In 1990, there were about 22 000 doctors registered in South Africa – of these, only about 1 000 were black doctors.*
- *In 1990 there were 3 581 dentists – only about 25 were black dentists.*
- *In 1990 there was one general practitioner for a population of 900 people in an urban area.*
- *In 1990, there was one general practitioner for a population of 4 100 people in the rural areas.*

Chapman and Rubenstein, 1998, 21

8.2.2 Current barriers to health care services

Despite the fact that our *Constitution* (*Act 108 of 1996*) guarantees freedom and equality for all, there are still many barriers that people face in getting access to health care services. Health care services are often expensive and most people do not have access to private medical aid to pay for expensive treatment. There is a general shortage of doctors. Many doctors and nurses are overworked. Some leave the country for better salaries overseas.

People living in poor, rural communities are most affected by these barriers:

- Many people do not know about certain diseases and how to prevent or treat them to ensure good health.
- There is a lot of prejudice and ignorance in some communities about HIV and AIDS. Some people living with HIV/AIDS fear that the community will reject them if they get tested and people find out that they are HIV positive and are taking ARVs.

- Health care facilities are often far away from where people live, and transport to these facilities is expensive.
- Health care facilities often do not have enough staff or medicines to provide proper health care services.
- Many people do not have access to clean water, sanitation, nutrition and electricity, and this also causes poor health. Many women travel long distances to fetch water, and this negatively affects their bones and muscles. A 1994 household health survey by CASE found that about two-thirds of the African population is affected by poor public health conditions – overcrowding, lack of electricity, clean water and sanitation (*Chapman and Rubenstein, 1998, 19*).
- Poor people face the high costs of transport, buying medicines, and follow-up visits to a doctor.
- Language barriers between patients and health care workers mean that many people may not be able to fully understand their treatment because the health care worker does not speak the patient's language.
- Many women experience domestic violence, sexual offences and other forms of violence against women.
- There are discriminatory attitudes amongst health care workers against people because of their race or gender.
- Because of the HIV/AIDS crisis, many hospitals and clinics face a huge increase in patients, but there has not been an increase in the doctors and nurses available to care for all the new patients.
- The health care system is also better equipped and provides a better service in some provinces like Gauteng and the Western Cape, than in others such as the Eastern Cape and Limpopo.

CASE STUDY

LACK OF INFRASTRUCTURE AND HEALTH FACILITIES AS BARRIERS TO HAVING ACCESS TO HEALTH CARE SERVICES

De Hope is a disadvantaged area in Limpopo. The town clinic covers six villages – Nhanganani, Njhakanjhaka, Doli, Matsele, Nkunzana and De Hope. Some patients have to travel by foot more than 10 kilometres to the clinic. On some parts of the road, they have to take off their shoes to cross the river.

The clinic does not have a telephone and there is a shortage of staff. Staff use their mobile phones for emergencies to communicate with the doctors at Elim Hospital. There is only one nurse for Voluntary Counselling and Testing (VCT). When she is upset, she does not come to work and no VCT is done until she comes back. Patients in a critical condition have to wait for the ambulance that takes time to come because it travels more than 70 kilometres to the clinic.

From 'A river, too few staff and a lack of ambulances hamper patient care', Joel Ntimbani, Treatment Action Campaign website

8.3 Your health rights in the Constitution

There are many constitutional rights that protect your health rights or are related to your health. Some of these rights are shown in the next table:

Section	What is the right?	Who benefits?
12(2)	The right to bodily and psychological integrity, including the right – • To make decisions on reproduction • To security in and control over your body • Not to be subjected to medical or scientific experiments without your informed consent	Everyone
24(a)	The right to an environment that is not harmful to your health or well being	Everyone
27(1)(a)	The right of access to health care services, including reproductive health care services	Everyone
27(3)	The right to emergency medical treatment	Everyone
28(1)(c)	The right to basic health care services	Every child
35(2)(e)	The right to adequate medical treatment at State expense	Everyone who is detained, including every sentenced prisoner

GUIDELINES

CONSTITUTIONAL HUMAN RIGHTS

- The Constitution gives special attention to the health rights of children and detained people. It recognises that these groups are particularly vulnerable and need stronger protection than everyone else.
- The health right of "everyone" in section 27(1)(a), to have "access to" health care services is qualified by "available resources". This means that the State has a duty to provide more and more people with better access to health care, but that it need not do more than it can with the amount of money available to it.
- The Constitution does not allow unfair discrimination on any grounds, including the grounds of race, sex, religion, age, marital status, disability and sexual orientation (for example, being gay or lesbian). In the 2000 case of *Hoffman v South African Airways*, the Constitutional Court ruled that unfair discrimination on the basis of HIV status was not allowed. This means that you cannot be denied access to a hospital, doctor or medical treatment, or to employment, just because you are living with HIV.

For the full Bill of Rights (Chapter 2 of the Constitution), see page 442.

There are also other important constitutional rights that affect health rights, including:

- The right to equality.
- The right to human dignity.
- The right to life.
- The right to privacy.
- The right to education.
- The right of access to adequate housing.
- The right of access to sufficient food and water.

8.4 Guides to interpreting your health rights

8.4.1 The right of access to health care services and the right to emergency medical treatment

a) Duty not to interfere and to respect health care rights

The Constitution places a duty on the State and on private health care providers not to interfere with a person's access to health care services. This is also called *the duty to respect* the right. This means that any action or conduct by the State or a private company that interferes with existing access to health care services, or would make it more difficult for an individual to gain access to existing health care services, could be a violation of the right to health.

EXAMPLES

INTERFERING WITH HEALTH CARE ACCESS

- *Where the State closes down a clinic in a rural area, and thus forces poor women and children to travel much further and pay more for transport to go to another clinic.*
- *Where the Minister of Health orders all doctors in public hospitals to stop treating patients with cheap and available drugs for any known illness.*

Section 27(3) of the Constitution supports the duty to respect health rights, saying that no-one may be refused emergency medical treatment.

COURT CASE

DIALYSIS TREATMENT NOT AN EMERGENCY MEDICAL TREATMENT

In the 1997 case of ***Soobramoney v Minister of Health, KwaZulu-Natal*** (Soobramoney case), the Constitutional Court said that "emergency medical treatment" refers to the treatment that is available in emergency situations, and is necessary to stabilise the patient and to avoid harm. An *emergency medical situation* is defined as a situation where a sudden disaster immediately endangers the life of a patient.

The Court decided that Mr Soobramoney, who was suffering from chronic kidney failure and wanted free access to a dialysis machine, was not requiring "emergency medial treatment" because his kidney failure was an ongoing condition.

b) Duty to take reasonable steps

For more on the duty to take reasonable steps, see Chapter 1 on page 32.

The Constitutional Court has on a few occasions described what 'the duty to take reasonable steps' means.

COURT CASE

MOTHER-TO-CHILD TRANSMISSION OF HIV

In the 2002 case of ***Minister of Health and Others v Treatment Action Campaign and Others*** (TAC case), the TAC took the Government to court to challenge the State's policy on mother-to-child transmission of HIV. The Court decided:

- Children are especially vulnerable and their needs are "most urgent" because, if they do not get access to nevirapine, they will die. In cases like these, poor children depend on the State to save their lives, and the Government's policy to not provide these life-saving drugs, was therefore unreasonable and unconstitutional.
- The Government's programme to progressively provide women living with HIV and their newborn babies access to nevirapine was unreasonable and unconstitutional. By restricting the provision of nevirapine to 20 pilot sites and by failing to provide for training for counsellors in the use of nevirapine, the State was rigid and unreasonable in its approach.
- The Government must take all reasonable measures to extend the testing and counselling facilities at State hospitals and clinics throughout the public health sector, and to facilitate and speed up the use of nevirapine for the purpose of reducing mother-to-child transmission of HIV.

CASE STUDY

REASONABLE ACTION

Imagine that the State plans and implements a programme to rid our society of TB, and targets only mine workers and their families. The programme does not target poor women and children in rural areas, who are also seriously affected by TB.

A court may find that the programme is not reasonable because it does not address the needs of some of the most vulnerable groups in society.

The Court's decision in the TAC case shows that the State has a constitutional duty to do as much as it possibly can, with available money, to protect the most vulnerable groups in our society from serious illness and death. Where it is possible for the State to save the lives of people who are poor and vulnerable (such as mothers and newborn babies who cannot afford private health care) and the State does not take reasonable steps to do this, a court will be able to declare that the State has not carried out its constitutional duty to provide access to health care.

CASE STUDY

AVAILABLE RESOURCES

Imagine that the State plans and implements a programme to rid our society of TB, and the programme targets mine workers and all other vulnerable groups, such as poor women and children in rural areas. The programme allows for education and treatment, and has a phased implementation. The Government budgets R500 million to implement the programme over three years.

But after six months, before the programme has actually been rolled out, the Minister of Health decides to use the money to build a monument to honour the work done by Cuban doctors in South Africa. The TB programme is then scrapped because of "a lack of resources".

A court may find that the excuse of a lack of resources is not constitutionally acceptable, because the money was already budgeted. The decision to build a monument, instead of fighting TB, can therefore not be reasonable.

c) International law

General Comment on right to health

While the South African Constitution provides for a right of access to health care services, article 12 of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) recognises the right of everyone to the highest attainable standard of physical and mental health.

For more on General Comments, see Chapter 3 on page 105.

The Committee on Economic, Social and Cultural Rights (CESCR) adopted *General Comment No. 14* on the right to health. Although the wording of the ICESCR is slightly different to the South African Constitution, the essential elements of the right to health in paragraph 12 of General Comment 14 are:

For more on these elements, also known as 'the 4-A scheme', see Chapter 12 on page 418.

- Availability
- Accessibility
- Appropriateness
- Acceptability.

Availability

Functioning public health and health care facilities, goods, services and programmes must be available in sufficient quantity within the State.

CASE STUDY

ESSENTIAL DRUGS

The South African Government's health policy says that all essential drugs should be available in public clinics and hospitals for common conditions like arthritis, TB, paediatric illnesses, high blood pressure and cardiac cases. However, patients complain that this does not happen. In Mdantsane, East London, patients at NU13 clinic complained that each time they visit their clinic, all they get is Panado.

This means that government in the Eastern Cape is not fulfilling its obligation to provide functioning public health care and to make it available in sufficient quantity.

'Managing medicine supply in the Eastern Cape', Health-e website, 27 February 2004

Accessibility

CASE STUDY

ACCESS FOR PEOPLE LIVING WITH DISABILITIES

Imagine there is an extensive government programme to build new clinics in rural areas. Unfortunately, the new buildings are not wheelchair accessible, and thus people with physical disabilities cannot get up the stairs into the clinics. This would mean that the Government had not fulfilled its obligation to make health facilities physically accessible.

Health facilities, goods and services have to be accessible to everyone without unfair discrimination. This includes physical accessibility, economic accessibility (affordability) and information accessibility.

Appropriateness

CASE STUDY

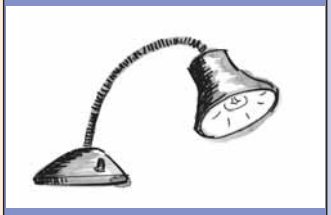
TESTING OF DRUGS

If the Department of Health allowed doctors or anyone else to prescribe herbal mixtures like *ubhejane* to people living with HIV without this product being scientifically tested to see if it works, it will be a breach of its international law duties.

Health facilities, goods and services must be scientifically and medically appropriate and of good quality.

Acceptability

EXAMPLE



INFORMED CONSENT

Medical ethics say that no person may be subjected to medical treatment or tests without their informed consent. Testing somebody for HIV without their approval will therefore also be a breach of international law duties.

All health facilities, goods and services must be respectful of medical ethics and culturally appropriate.

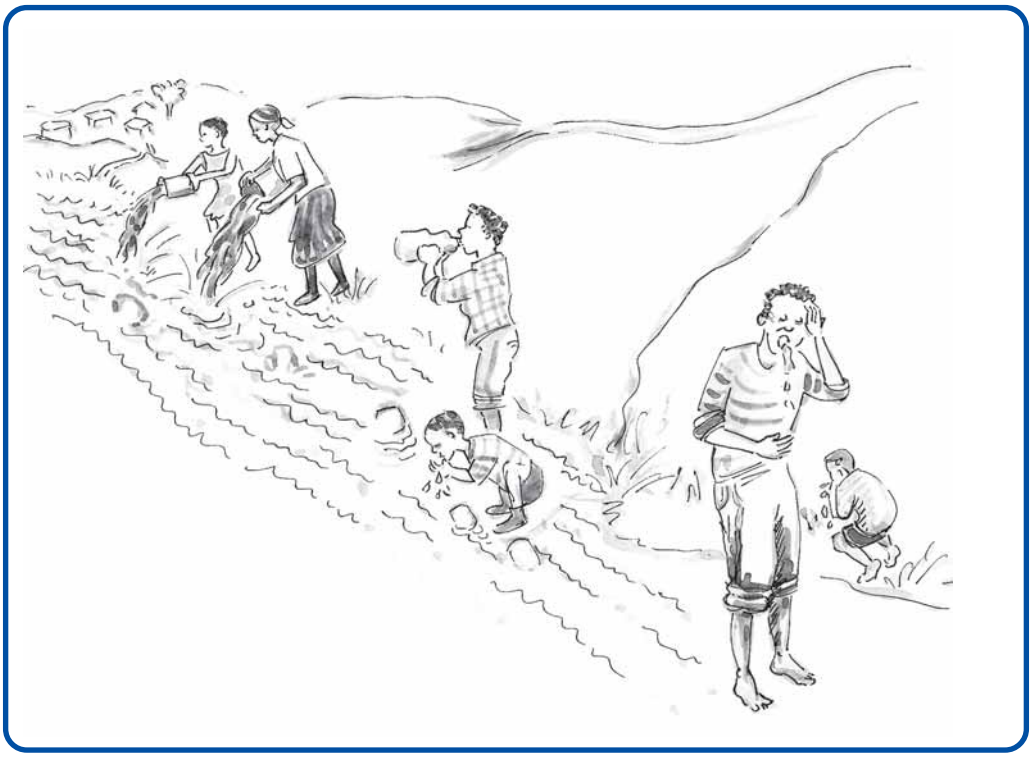
General Comment 14 also stresses that each State has the duty to realise at least the 'minimum core obligations' of the right to health, including the duty:

For more on the idea of a 'minimum core obligation', see Chapter 1 on page 39.

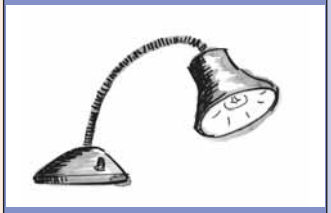
- To ensure the right of access to health facilities, goods and services in a non-discriminatory way, especially for vulnerable or marginalised groups.
- To ensure access to the minimum essential food that is nutritionally adequate and safe, to ensure freedom from hunger for everyone.
- To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and drinkable water.

For more details on the Model List of Essential Drugs, go to the WHO website address on page 310.

- To provide essential drugs, as defined under the World Health Organisation (WHO) Action Programme on Essential Drugs.
- To ensure equitable distribution of all health facilities, goods and services.
- To adopt and implement a national public health strategy and plan of action to address the health concerns of the whole population.
- To plan and review the strategy and plan of action in a participatory way, including giving special attention to all vulnerable or marginalised groups.



EXAMPLE



WHO ESSENTIAL DRUGS

Every two years, the WHO issues a Model List of Essential Drugs. The 14th revised list was issued in March 2005 and includes a list of antiretroviral (ARV) drugs. This means that, under international law, the State has a duty to at least provide all people needing ARVs with these drugs.

General Comment on women and health

The Committee on the Elimination of Discrimination against Women adopted *General Comment No. 24* on women and health in 1999. Article 12 of the *International Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW) places a duty on States to eliminate discrimination against women in the field of health care, meaning that:

- It would be unacceptable for a State to refuse to provide all women with access to reproductive health services.
- States cannot stop women from accessing health care services on the grounds that they do not have permission of husbands, partners or parents, or because they are not married.
- States have a duty to pass laws that ban female genital mutilation.

General Comments on HIV/AIDS and the rights of the child

In 2003, the Committee on the Rights of the Child (CRC Committee) adopted two General Comments that are important for our understanding of children's right to health care. In *General Comment No. 3*, the CRC Committee addressed HIV/AIDS and the rights of the child:

- HIV and AIDS have a devastating effect on the lives of children, affecting not only the right to health but all the rights of children.
- Children are especially vulnerable to the effects of HIV/AIDS because they may be orphaned by HIV/AIDS, or may be the victims of sexual and economic exploitation or other violent abuse.

The CRC Committee also adopted *General Comment No. 4*, dealing with adolescent health and development:

- Adolescents have a right of access to information that is essential for their health, including information about sexual and reproductive health, and HIV prevention.
- States have a duty to create safe and supportive environments for adolescents within the family, in schools and in all other kinds of institutions.
- States have a duty to protect adolescents from harmful traditional practices, such as early marriage and female genital mutilation.

8.4.2 The right to make decisions on reproduction

COURT CASE

INTERPRETING THE RIGHT TO MAKE DECISIONS ON REPRODUCTION

This right was discussed in the 1998 case of *Christian Lawyers Association of SA v Minister of Health* (first Christian Lawyers Association case). The Christian Lawyers Association challenged the *Choice on Termination of Pregnancy Act 92 of 1996*, allowing women access to abortion. They argued that the law violated the right to life of the fetus and was therefore unconstitutional.

In deciding whether the legislation went against the Constitution, the Court considered the right to life in section 11, and the right to bodily and psychological integrity in section 12(2) of the Constitution. The Court decided:

- The term "everyone" in section 11 of the Constitution did not include a fetus.
- Section 12(2) gave everyone the right to make decisions on reproduction.
- This section also gave everyone the right to security in and control over their bodies.
- The Constitution did not limit this right by saying that a woman had this right only to the extent that it did not harm her fetus.

The Christian Lawyers Association case showed that, as part of the right to make decisions on reproduction, women can choose to have an abortion under the circumstances allowed by the Choice on Termination of Pregnancy Act.

8.4.3 The right of access to reproductive health care services

While there has been no case law in South Africa dealing specifically with the meaning of reproductive health care services, we can be guided by international law.

CEDAW prohibits discrimination against women in all its forms, including access to health care services and those related to family planning. It says States must ensure appropriate services in connection with pregnancy, confinement and the post-natal period, including granting free services where necessary, as well as adequate nutrition during pregnancy and breastfeeding.

The *Beijing Declaration and Platform for Action*, adopted by the Fourth World Conference on Women in 1995, has this definition of *reproductive health*:

> "Reproductive health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and they have the capability to reproduce and the freedom to decide if, when and how often to do so.
>
> Men and women have the right to be informed and to have access to safe, effective, affordable and acceptable methods of their choice for the regulation of their fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.
>
> Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases." *Paragraph 94*

The WHO says that a minimum level of reproductive health services should include:

- Family planning.
- Sexually transmitted disease prevention and management.
- Interventions for safe motherhood (*WHO, 1995, 1*).

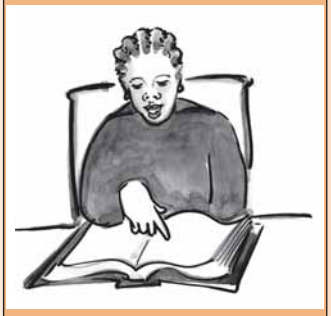
8.4.4 The right of detained people to adequate medical treatment

Section 35(2)(e) of the Constitution protects the right of detained people to adequate medical treatment. This includes everyone who is deprived of their liberty, for example, sentenced prisoners and people committed to psychiatric institutions. This section says:

- Medical treatment must be adequate.
- The treatment must be provided at State expense.

On pages 288–289, we see how our courts have interpreted the right to "adequate medical treatment at State expense" in the Van Biljon and EN cases.

COURT CASE



THE RIGHT OF PRISONERS TO ADEQUATE MEDICAL TREATMENT

The meaning of section 35(2)(e) was tested in the 1997 case of ***Van Biljon and Others v Minister of Correctional Services*** (Van Biljon case) in the Cape High Court. The Court ordered the Department of Correctional Services to provide combination ARV therapy to two prisoners. The Department of Correctional Services had said that prisoners did not have greater rights than patients at State hospitals, who were at that stage not receiving this treatment, and that the drugs were far too expensive.

The Court decided:

- The Constitution did not give prisoners the right to the best medical treatment, but only to "adequate" treatment.
- A prisoner's right to medical treatment depends on an examination of circumstances, such as prison conditions, to decide what is adequate.
- The meaning of adequate medical treatment has to be linked to what the State can afford.
- As the two prisoners had been prescribed ARV treatment by a doctor, this was considered "adequate medical treatment" for their condition and circumstances.
- This decision did not mean that all prisoners with HIV should receive expensive drugs.

The Court summarised its approach:

> "Even if it is accepted as a general principle that prisoners are entitled to no better medical treatment than that which is provided by the State for patients outside, this principle can, in my view, not apply to HIV infected prisoners. Since the State is keeping these prisoners in conditions where they are more vulnerable to opportunistic infections than HIV patients outside, the adequate medical treatment with which the State must provide them must be treatment which is better able to improve their immune systems than that which the State provides for HIV patients outside."
>
> *Paragraph 54*

COURT CASE

RIGHT OF PRISONERS TO ANTI-RETROVIRALS

In the 2006 case of *EN and Others v The Government of South Africa and Others* (EN case), prisoners living with HIV in the Westville Correctional Centre challenged the slow implementation of the Government's plan to provide ARVs to prisoners needing them. The Durban High Court agreed that this was a matter of life and death, and said that the prison officials showed a lack of commitment to appreciate the seriousness and urgency of the situation.

Relying on the judgment in the Grootboom case, the Court decided that the Westville Correctional Centre's implementation of the relevant laws and policies in this case was unreasonable because it was inflexible, and characterised by unexplained and unjustified delays and irrationality. The court also hinted that the Government's *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa* itself is faulty itself because it did not properly consider the special vulnerability of prisoners to HIV/AIDS.

The Court ordered the Westville Correctional Centre:

- To immediately remove all restrictions that prevented prisoners needing ARVs from accessing them.
- To immediately provide all the applicants in the court case with access to ARVs.
- To submit a plan to the Court to explain how they plan to comply with the orders made by the Court *(paragraph 35 of judgment)*.

For more on contempt of court, see Chapter 2 on page 79.

The State appealed against this judgment to a full bench of the KwaZulu-Natal High Court. On 28 August 2006, the full bench dismissed the State's case and found it to be in contempt of the court order. The Court:

- Raised serious concerns about the fact that, when the State is in contempt of court orders, the Court cannot enforce these orders by imprisoning the responsible government officials. This is because section 3 of the *State Liability Act 20 of 1957* protects them against imprisonment for their actions while in office.
- Said that, unless the State Liability Act is declared unconstitutional, there is no mechanism for enforcing contempt of court orders against government officials.

The Court then ordered the State to implement without delay the original court orders unless and until another court sets aside these orders on further appeal.

Muntingh and Mbazira, 2006, 14–16

8.5 Policies, legislation and programmes to implement your health rights

The policies and laws passed by the Government describe in more detail the meaning of these constitutional rights, who must implement them and how they must be implemented. They help us to assess whether or not the Government is taking reasonable steps to realise our health care rights.

There are many laws dealing with different aspects of health care. In this part, we will discuss only some of the key policies and laws.

8.5.1 The White Paper on Health

The *White Paper on the Transformation of the Health System* (1997) sets out key health policy issues. It aimed to:

- Unify the national health system to address the effects of apartheid on health.
- Re-organise the health service to give priority to primary health care through the district health system, where certain aspects of health service delivery take place at district (instead of national or provincial) level. A clear advantage of the district health model is that it is another step to bringing health care services closer to the people on the ground.
- Recognise the need to increase access to services by making primary health care services available to all people.
- Ensure that there are safe, good quality essential drugs available in all health facilities.
- Strengthen disease prevention.
- Promote health.
- Give special attention to health services reaching people most in need of these services – the poor, the underserved, the elderly, women and children.
- Promote the participation of community structures in health care delivery.

8.5.2 Legislation

a) The National Health Act

The *National Health Act 61 of 2003* came into force in May 2005 and is the most important piece of legislation that helps to implement the constitutional rights on health. Although other laws deal with specific aspects of health rights, the National Health Act is the main law that gives clear overall direction on health rights in South Africa.

Some of the aims of the National Health Act are to:

- Make effective health services available to the population equitably and efficiently.
- Protect, respect and fulfil the rights of the people of South Africa to progressively realise the constitutional right to health.
- Establish a national health system that will provide people with the best possible health services that available resources can afford.

GUIDELINES

PEOPLE WHO CAN GET FREE PUBLIC HEALTH CARE

State and State-funded clinics and community health centres must give:

- Free medical services to pregnant and lactating women, and children younger than the age of 6, who are not on medical aid schemes.
- Free primary health care to all people, except those on medical aid schemes or those receiving compensation for occupational diseases.
- Free termination of pregnancy services under the Choice on Termination of Pregnancy Act 92 of 1996.

Free health care

The National Health Act allows for some people to get free health care in public health services.

Emergency treatment

The National Health Act also gives special protection to people needing emergency medical treatment. The Act says that a public or private health care provider (eg a hospital), health worker (eg a doctor or nurse) or health establishment (eg a chemist) may not refuse anyone emergency medical treatment.

Privacy and confidentiality

A health care professional, such as a doctor or nurse, may not give any information to any other person about a patient's health status, treatment or stay in a public or private hospital. The National Health Act provides for situations when information must be given to other health care professionals to help with the treatment of a patient, or where the patient has consented.

COURT CASE

CONFIDENTIALITY

In the 1993 case of *Jansen van Vuuren and Another v Kruger*, the Appeal Court had to rule on the duty of a doctor to keep information about a patient private and confidential. The applicant, Mr McGeary, had tested HIV positive. His doctor then revealed this information to two colleagues during a game of golf. Mr McGeary then brought an action against his doctor for damages for the breach of his privacy. In other words, he was claiming money from his doctor for not respecting his right to privacy and confidentiality.

The Appeal Court said:

- People living with HIV/AIDS have a right to privacy, especially when this right is based on a doctor-patient relationship.
- The doctor had no duty to give this information to his colleagues, who also did not have a right to receive the information.

GUIDELINES

SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL ETHICAL GUIDELINES ON HIV/AIDS (1995)

A doctor is only allowed to disclose HIV-related information when:

1. The patient consents, or
2. A court order or any other law says there must be disclosure, or
3. If the spouse or partner of the person with HIV is at risk and where, even after repeated counselling, the person with HIV refuses permission – then and only to protect the spouse or partner, the doctor may disclose the HIV information.

CASE STUDY

USING THE SAMDC ETHICAL GUIDELINES

Dr Reed tests and diagnoses Peter with HIV. After advising Peter to tell his sexual partner, Mandla, that he has HIV, Peter still refuses and continues having unprotected sex with Mandla. Dr Reed may tell Mandla that Peter has tested HIV positive because of the dangers Peter's actions are causing to him. Dr Reed may only tell Mandla, who is an identifiable sexual partner, once he has told Peter that he will be doing this.

COURT CASE

CONSENT TO MEDICAL PROCEDURES

In the 1923 case of ***Stoffberg v Elliot***, the Cape Supreme Court stressed the importance of a patient's consent to medical procedures. The Court decided that:

- Entering a hospital does not mean that a patient agrees to any surgical treatment doctors may consider necessary without the patient's consent.
- Even after entering a hospital, a person still maintains control over his/her body, and has the right to say what operation he/she will submit to.
- Any operation performed without the patient's consent is unlawful because it does not respect the patient's right to personal security and control of their body.

CASE STUDY

NO CONSENT

Leila is not feeling well, so she goes to visit Dr Shabalala. Leila consents to Dr Shabalala doing a pregnancy test. However, in addition to doing a pregnancy test, Dr Shabalala does an HIV test on Leila's blood sample, but Leila has not consented to an HIV test.

Full knowledge and consent

The National Health Act says that no person may be tested, treated or have any other medical procedure done on them without their informed consent. This consent must be given freely and voluntarily. As a patient, you can only give informed consent to medical treatment after you have been given all the information needed to make your decision.

This means that the health care worker must explain to you as the patient:

- Your current health status.
- The range of procedures and treatment options available.
- The benefits, risks, costs and consequences usually linked to each option.
- Whether or not you have a right to refuse to have medical treatment.

The *Children's Act 38 of 2005* says that a child of 12 may consent independently to medical treatment only if the child is mature enough to understand the implications of the treatment. The Act also states that a child may only be tested for HIV when:

- It is "in the best interests of the child", or
- If the test is necessary to establish whether a health care worker may be at risk of HIV infection due to coming into contact with any substance from the child's body that may transmit HIV.

GUIDELINES

NATIONAL POLICY ON HIV TESTING

The National Policy on Testing for HIV sets out the circumstances when HIV testing can take place, and how HIV testing should be done:

1. Testing for HIV may only be done with informed consent (except in a few cases, set out in the Policy).
2. Pre-test counselling must be given to each person before the test.
3. Post-test counselling must be given after the person gets the test result:
   - If the result is HIV negative, then the person should be told how to stay negative, and to test regularly.
   - If the result is HIV positive, the person should be given emotional support, and guidance on who to inform and how to reduce the risk of HIV infection to sexual partners.
4. If a hospital or clinic is not able to do counselling, it must refer the person to another place for counselling. *AIDS Law Project website*

Laying of complaints

The National Health Act also says that every person has the right to lay a complaint about the way he/she was treated at any health establishment by any of the staff. Any hospital, clinic or other State or private health facility has a duty to display the procedure for making a complaint at the entrance to the facility where anyone will easily be able to see it.

b) The Mental Health Care Act

The *Mental Health Care Act 17 of 2002* recognises that health is a state of physical, mental and social well being, and that mental health care services should be provided at all levels of the health system.

The Act aims to:

- Regulate the mental health care environment in a way that allows the best possible mental health care, treatment and rehabilitation that available resources can afford.
- Set out the rights and duties of the mental health care user, and the duties of mental health care providers.
- Respect the human dignity and privacy of every mental health care user – this means that, as a user, you must receive the care, treatment and rehabilitation services that improve your mental capacity to develop to your full potential and to facilitate your integration into community life.

c) The Sterilisation Act

The *Sterilisation Act 12 of 1998* allows for a right to sterilisation and sets out the circumstances when a sterilisation can be performed. *Sterilisation* is a surgical operation to make a woman incapable of falling pregnant.

The Sterilisation Act also deals with the sterilisation of people with a severe mental disability. It explains what "severe mental disability" means and who needs to consent when a person has a severe mental disability, and wants or needs to be sterilised.

CASE STUDY

CONSENT TO STERILISATION

- For Yasmin, who is older than 18, to be sterilised under this law, she needs to be given a clear explanation and description of exactly what will be done. She must give free and voluntary consent to it. Yasmin may also withdraw her consent at any time before the treatment begins. Yasmin does not need her husband's consent to be sterilised. She just needs to give her consent, and be 18 or older, to be sterilised.
- Yasmin's younger sister, Fatima, who is under 18, may only be sterilised if her life or physical health will be seriously harmed if she is not sterilised. However if this happens, Fatima's parent or guardian would need to give consent.

d) The Choice on Termination of Pregnancy Act

The Choice of Termination of Pregnancy Act gives every woman the freedom to choose whether to have an early, safe and legal termination (ending) of pregnancy, according to her beliefs. The Act allows you to have your pregnancy terminated on request during your first 12 weeks of pregnancy. All that is needed is your informed consent.

GUIDELINES

TERMINATION OF PREGNANCY

1. The Act makes it easier to get an abortion in your first 12 weeks of pregnancy, so it is important that people wanting an abortion approach their doctor as early as possible.
2. Although the Act allows for a person to have an abortion from the 13th week to the 20th week, this can only be done:
   - After consultation between the doctor and pregnant woman, and
   - If, for example, the doctor thinks the pregnancy would pose a risk to the woman's health, or there is a substantial risk of abnormality of the fetus, or the pregnancy resulted from rape or incest, or the continued pregnancy would significantly affect the social and economic circumstances of the woman.
3. The law allows for a termination of pregnancy after the 20th week in very limited circumstances.
4. The law says the State should try and provide optional counselling before and after the abortion, so you should ask if this counselling is available.
5. Only the consent of the woman wanting the abortion is needed. That means the consent of the woman's husband or the father of the fetus is not needed.
6. Young women under 18 should consult with their parents, guardian, family members or friends before the termination, but cannot be denied the right to terminate their pregnancy if they choose not to consult.

COURT CASE

A PREGNANT MINOR DOES NOT HAVE TO GET PERMISSION FOR A TERMINATION OF HER PREGNANCY

In the 2004 case of *Christian Lawyers Association of SA v Minister of Health* (Second Christian Lawyers Association case), the applicants argued that sections of the Choice on Termination of Pregnancy Act were unconstitutional. They claimed that the Act allowed a woman younger than 18 to choose to have her pregnancy terminated without consent from her parents or guardians, without consulting the parents or guardians, without first undergoing counselling, or having to reflect on the decision for a period of time.

The High Court rejected these arguments. The Court pointed out the Act said that, as long as a woman is capable of giving informed consent to the termination of pregnancy, no other person's consent is required:

- This was in line with the Constitution that protected the right of "every woman" to make decisions about their bodies and about reproduction.
- As long as a woman – no matter how young – was mature enough to give informed consent, the Constitution guaranteed her right to have her pregnancy terminated.

e) The Tobacco Products Control Amendment Act

The *Tobacco Products Control Amendment Act 12 of 1999* was introduced to deal with the harmful effects of tobacco on the health of people. It prohibits:

- The advertising and promotion of tobacco.
- The free distribution of tobacco products.
- The smoking of tobacco products in any public place or workplace.

f) The Medical Schemes Act

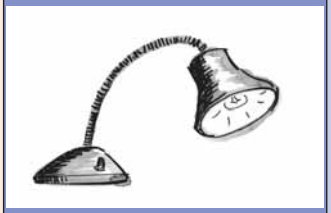
One of the aims of the *Medical Schemes Act 131 of 1998* is to protect the interests of members of medical schemes by setting out guidelines on the terms and conditions for membership of schemes. The Act prohibits:

- Unfair discrimination on a number of grounds.
- *Risk rating* – in other words, making people pay more because they are seen as being part of a 'higher risk' group.

The Act says the premiums that people have to pay must be based on income and number of dependants. The premium may *not* be based on any other grounds, including:

- Sex.
- Past or present state of health of the applicant or the applicant's dependants.
- The frequency of providing relevant health services to the applicant or dependants of the applicant.

EXAMPLES



PREMIUMS UNDER MEDICAL SCHEMES

If you are living with HIV and use health services very often, you cannot be denied access to a medical scheme or charged higher rates because of these factors. Your premium can only be based on your income and number of dependants, although there may be a penalty if you join the medical scheme late.

However, the Act does impose certain penalties for late joiners to medical schemes. A *late joiner* means an applicant or the dependant of an applicant who, at the date of application for membership, is 40 or older and has not been a member of another medical scheme during a period of two years before applying for membership. Regulations under the Act set out the maximum penalties in these circumstances.

g) The Medicines and Related Substances Control Amendment Act

The *Medicines and Related Substances Control Amendment Act 90 of 1997* controls the manufacture, sale and distribution of medicines. One of its important functions is to set out steps to ensure the supply of affordable medicines. The Act allows the Minister to lay down conditions for the supply of more affordable medicines in some circumstances to protect the health of the public. This includes provisions that can lower the cost of prescription drugs bought at chemists.

COURT CASE

A SINGLE ADMINISTRATION FEE NOT VALID

In the 2005 case of ***Minister of Health and Another v New Clicks and Others***, the Constitutional Court had to decide on the validity of regulations made under the Medicines and Related Substances Control Amendment Act. These were aimed at lowering the price of medicines sold by pharmacies. The regulations set a single price for each medicine and allowed all pharmacies only to charge an administration fee set at R26.

A majority of the judges decided:

- The regulations as a whole were valid and were aimed at lowering the price of medicines and improving access to health care for all.
- The setting of a single administration fee was not valid – they said that the single administration fee did not take into account that rural pharmacies differ from city pharmacies, and that rural pharmacies may need a higher administration fee to enable them to survive.

Chief Justice Chaskalson sums up the approach of the majority of the Constitutional Court:

> "An allegation has been made by professional organisations representing pharmacists that the dispensing fee will destroy the viability of pharmacies, and impair access to health care. That allegation is supported by a sufficient body of evidence to show that this is a real possibility. In the circumstances, the applicants were under an obligation to explain how they satisfied themselves that this would not be the result of the dispensing fee prescribed in the regulations. They were the only persons who could provide this information. They did not, however, do so. In the absence of such explanation, there is sufficient evidence on record to show that the dispensing fee is not appropriate." *Paragraph 404*

h) The Correctional Services Act

The *Correctional Services Act 111 of 1998* places a duty on the Department of Correctional Services to provide all prisoners with adequate health care services. Adequate health care is based on the principles of primary health care in order to allow every prisoner to lead a healthy life. The Act says that every prisoner has the right to adequate medical treatment, but that no prisoner has a right to cosmetic medical treatment, such as the removal of tattoos or implants of breasts at State expense.

The Act also says that every prisoner has the right to be visited and examined by a medical practitioner of his/her choice and may be treated by this practitioner as long as the Head of Prison has given permission. In this kind of case, the prisoner will have to pay for the medical treatment.

The Act prohibits anyone from forcing a prisoner to undergo medical examination, intervention or treatment without informed consent, unless this will be a threat to the health of other people in prison. But consent to surgery is not needed if a medical doctor decides that it is in the interests of the prisoner's health, and the prisoner is unable to give consent because he/she is unconscious.

For more on the health care rights of prisoners, see the cases on pages 288–289.

i) The Children's Act

The Children's Act aims to protect children living with disabilities and with chronic illness. In section 11(3), it says that a child with a disability or chronic illness has the right not to be subjected to medical, social, cultural or religious practices that are detrimental to his/her health, well being or dignity.

The Act also restricts virginity testing and outlaws female genital mutilation or circumcision. Male circumcision is also restricted. Section 12(8) of the Act prohibits circumcision of male children under the age of 16, except when:

- Circumcision is performed for religious purposes in accordance with the practices of a specific religion, or
- Circumcision is performed for medical reasons on the recommendation of a medical practitioner.

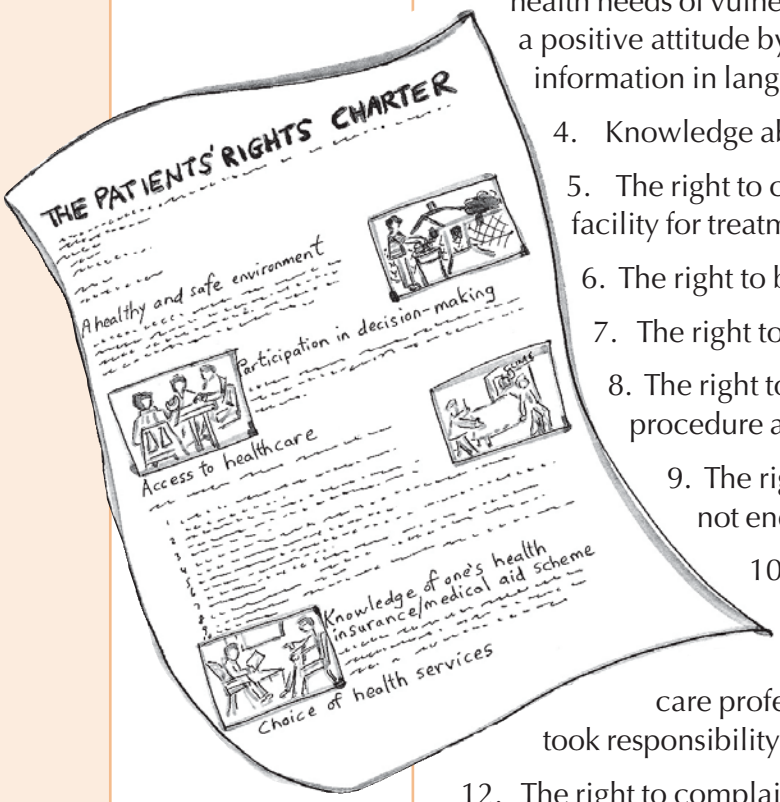
The Act further restricts the circumcision of male children older than 16:

- The child must give consent after proper counselling, as set out in regulations.
- Any male child has the right to refuse circumcision, taking into account the child's age, maturity and stage of development.

8.5.3 The Patients' Rights Charter

In 1999, the Department of Health adopted the *Patients' Rights Charter* to help ensure realising the constitutional right of access to health care services. Although not a legally binding document, the Charter is meant to be the common standard for achieving the realisation of the right of access to health care services. The Charter covers the rights and responsibilities of patients.

A patient's rights under the Charter include:



1. The right to a healthy and safe environment.
2. The right to participate in decision-making on health policies and issues affecting your health.
3. The right of access to health care services, including receiving timely emergency care, treatment and rehabilitation, provision for the special health needs of vulnerable groups, counselling without discrimination, a positive attitude by health care workers, and necessary health information in language that the patient can understand.
4. Knowledge about health insurance or medical aid schemes.
5. The right to choose a particular hospital, clinic or other health facility for treatment.
6. The right to be treated by a named health care provider.
7. The right to privacy and confidentiality.
8. The right to only have an operation or another medical procedure after giving informed consent.
9. The right to refuse treatment as long as this refusal does not endanger the health of others.
10. The right to be referred on to another health care worker for a second opinion.
11. The right not to be abandoned by a health care professional worker or a health facility that initially took responsibility for your health.
12. The right to complain about health care and have these complaints investigated, and to receive a full report of the investigation.

A patient's responsibilities under the Charter include:

1. To take care of your own health.
2. To care for and protect the environment.
3. To respect the rights of other patients, health care workers and health care providers.
4. To use the health care system fully and not to abuse it.
5. To know your local health services and what they offer.
6. To provide health workers with relevant and accurate information to help health care workers to diagnose, treat, rehabilitate or counsel you.
7. To advise health providers of your wishes for when you die.
8. To follow the prescribed treatment or rehabilitation, and to arrange to pay for these.
9. To enquire about any related costs of treatment or rehabilitation, and to arrange to pay for these.
10. To take care of health records in your possession.

8.5.4 The draft Health Charter

The Government has produced a draft Health Charter aimed at regulating the health sector in South Africa. The draft Health Charter says that all stakeholders have an important and meaningful role to play in conducting their business in a manner that it is ethical, honest and fair, and that satisfies the needs of patients.

All stakeholders agree *not* to:

- Overservice or overcharge consumers of health services.
- Interfere with the independence of practitioners in practising their professions in the best interests of their patients.
- Exploit or influence health care professionals to act in a way that may go against the ethical codes of their professions.

Stakeholders also agreed to ensure that the rights of patients reflected in the National Patients' Rights Charter are respected and that the Health Charter is implemented in a way that is consistent with the National Patients' Rights Charter. By June 2006, the Health Charter had not been finalised and implemented.

8.6 Protecting and advancing health rights

Health rights offer great potential for civil society organisations to lobby for legislative reform, to engage in advocacy and campaigns, to monitor and make complaints, and to litigate to advance these rights. In this part, we will discuss each of these strategies to advance, protect and defend health rights.

8.6.1 Lobbying for legislative reform

Lobbying for legislative reform can be used to further advance, protect or defend health rights. For example, extensive lobbying by NGOs working in the area of gender equality and women's health played a vital role in the passing of the Choice on Termination of Pregnancy Act. These NGOs made submissions to the Health Portfolio Committee and attended public hearings on the Choice on Termination of Pregnancy Bill.

The Reproductive Rights Alliance spearheaded these efforts. Joint initiatives between different organisations working in a sector always give lobbying activities greater strength and impact.

The Constitutional Court has said that the State's implementation of the right of access to health care services would only be reasonable if it also targets the most vulnerable groups in our society. This means that there is scope for groups who champion the rights of vulnerable groups such as women, farm workers, domestic workers or people living with HIV to lobby for legislation to protect the health of these people and to increase their access to health care services.

8.6.2 Campaigning to further health rights

Human rights campaigns can mobilise civil society organisations to debate, discuss and make demands that take forward the health rights of specific groups or everyone in society.

CASE STUDY

THE TREATMENT ACTION CAMPAIGN

For more on the TAC case, see Chapter 1 on page 32.

Launched in 1995, the Treatment Action Campaign (TAC) is a civil society organisation aiming to:

- Campaign against stigma and the idea that developing AIDS is automatically a death sentence.
- Raise public awareness and understanding that HIV/AIDS treatments are available and that people should be able to afford these treatments.
- Promote access to treatment as an incentive for people to volunteer for HIV testing, and to improve openness around HIV and AIDS.
- Increase treatment literacy, including detailed knowledge on ARV treatment.

Between 2000 and 2002, the TAC launched a campaign to get the Government to provide the drug nevirapine to mothers living with HIV and their new-born babies to prevent the mother-to-child transmission of HIV. The campaign of the TAC succeeded in getting the Government to change its policy while the Constitutional Court was still deciding the case in 2002.

The TAC has continued with other campaigns, in partnership with other organisations, to advance its aims. Campaigns in 2005 included:

- Monitoring the State's rollout of ARV treatment and calling for speeding up the rollout.
- Marching to specific hospitals to demand ARV treatment.
- Pressurising for lowering the prices of some ARVs.
- Organising protests against Dr Mathias Rath, who sells vitamins and claims that they are more effective in stopping HIV than ARVs. This led to a court case in July 2005 to attempt to stop the activities of the Rath Foundation.

The TAC has also formed sectoral committees in the labour movement and the health, religious, youth and women's sectors. These specialised sectors work to mobilise their constituencies to achieve the aims of the TAC such as wider access to ARV treatment.

Lessons we can learn from the TAC

The TAC uses the right of access to health care in the Constitution to claim their rights, but they do not go to court at the start of a campaign. They first engage with the Government or a drug company. They often start a campaign through mass action, media activities and personal meetings.

Then, if this is not successful, they threaten legal action while continuing to put pressure on the Government or the drug company. As a last resort, they may need to go to court to claim their rights, usually when there is already strong public opinion in their favour.

GUIDELINES

RUNNING A HEALTH CAMPAIGN

1. Choose a specific health issue (eg access to ARVs), or a specific project aimed at furthering health rights (eg the draft Health Charter). This will help to keep the campaign more focused and easier to manage.
2. Have a clear list of exactly what is being demanded (eg interpreters within the health sector, nevirapine for pregnant women).
3. Be clear on who the demands are being addressed to (eg TAC aiming a campaign at both the Government and drug companies).
4. Mobilise relevant sectors through public education, using creative methods, such as billboards and radio slots.
5. Let your campaign aims and target groups guide the specific details of the campaign approach and strategies. For example, if you wish to reach schools, adapt your messages to appeal to younger people.

For more on campaigns for advancing health rights, see Chapter 2 on page 71.

8.6.3 Monitoring the provision of health care services

The problem of national laws and policies not being properly implemented is one of the greatest challenges facing the health sector. It is very important that civil society organisations carefully monitor the implementation of laws.

GUIDELINES

MONITORING HEALTH SERVICES

1. When monitoring health services, you can do this for a specific area or institution, or for the health service as a whole. Be clear on the purpose of the monitoring. For example, the results could be used:
   - To influence policy and legislation, or
   - To make a complaint to the South African Human Rights Commission (SAHRC) or a health structure, such as the Health Professions Council of South Africa.
2. Establish the area or place that will be monitored. For example, monitoring may take place within a particular health care facility (eg a hospital), a particular area (eg Soweto), a particular province (eg the Western Cape) or nationally.
3. Establish what particular health service is being monitored (eg the implementation of the Choice on Termination of Pregnancy Act).
4. Establish how you will monitor. For example, is it going to be through interviews with patients, or examining the records of a health care facility, or a combination of both methods?
5. Establish the standards you will use to assess the health care service. This can include standards that the Department of Health has set for itself or standards set by the WHO.
6. Identify key reports and other documents that can give you vital information. For example, if you are monitoring the health service as a whole, note that:
   - The Constitution directs the SAHRC to monitor realising the right of access to health care and to compile a report each year to show what steps the Government has taken.
   - The annual SAHRC report has lots of useful information to help you monitor the overall performance of the health sector.
   - You can compare the latest report with reports from previous years to check if any progress has been made.

CASE STUDY

QUALITY HEALTH CARE NOT DELIVERED EQUITABLY

The Government has developed legislative and other measures to comply with its constitutional duties under section 7(2) of the Constitution. However, despite national policies and programmes that mostly follow international standards and targets, the health care system has not been able to successfully deliver quality health care on an equitable basis in all the provinces.

For example:

- Provinces do not spend the same amount for each person on health care delivery, with rich provinces like Gauteng and the Western Cape far exceeding the amount spent by poor provinces such as Limpopo, Mpumalanga and the Eastern Cape.
- There is a serious lack of managerial capacity in the health system – the biggest challenge facing the efficient running of the health system is training managers to implement efficient systems in running clinics and hospitals where many problems have been identified. Problems include insufficient cleaning staff, nurses, doctors, dentists, pharmacists, psychologists and specialists.
- These problems place an enormous pressure on existing staff. New staff members are often unhappy with their working conditions, leading to some of them resigning. Many opt for better remuneration and working conditions in the private health care sector or go abroad.

'The Right to Health Care: 5th Economic and Social Rights Report Series, 2002–2003 Financial Year', SAHRC, SAHRC website, 21 June 2004

8.6.4 Making complaints against health authorities

The National Health Act says that there must be guidelines on procedures to be followed by users making complaints, claims or suggestions on the provision of health care services. Every health care establishment (for example, a hospital or a clinic) must display the procedure for laying a complaint at its entrance so that it is visible to everyone. Every complaint received must be acknowledged.

Complaints can also be made to the Councils that license doctors, nurses and other health professionals about the way a particular health professional treated you, for example:

- The Health Professionals Council of South Africa (HPCSA) controls the training and conduct of doctors.
- The South African Nursing Council (SANC) oversees the training and conduct of nurses.

In 2002, the Minister of Health issued new regulations on the suspension of health care practitioners. They could be suspended after a complaint about:

- Actual physical or mental abuse of a patient by a practitioner, or a substantial risk of physical or mental abuse.
- Harm or injury to a patient as a result of unsafe professional practices or a substantial risk of harm or injury.

- Evidence of drug abuse by a practitioner that harms the practitioner's ability to give a professional service.
- Any act by a practitioner that, in the opinion of the professional board, substantially lowers the dignity or damages the reputation of people practising the profession.

a) The HPCSA

GUIDELINES

HOW TO MAKE A COMPLAINT TO THE HPCSA

The complaint must be in writing and must give these details:

- The history of the complaint.
- The name of the person complaining (the *complainant)* and the name of the person the complaint is against (the *respondent*).
- The date and place of the incident.
- How the incident happened.

GUIDELINES

HPCSA PROCEDURES AFTER RECEIVING A COMPLAINT

1. Within three days after a complaint is lodged with the registrar of the HPCSA, it must request the complainant to confirm the content under oath. The registrar can then ask for more information from the complainant.
2. The registrar must gather as much information as possible, and forward it to the chairperson of the professional board.
3. If there is enough evidence, an 'ad hoc committee' will consider the complaint.
4. The registrar will arrange for the hearing to take place, and will issue a summons to the complainant and provide him/her with all the relevant information.
5. At the hearing the committee may ask anyone to give oral evidence. The respondent will also be allowed to ask questions of anyone giving evidence.
6. The committee will then make a decision about the suspension of the health care practitioner.
7. If you are not happy with the outcome of your complaint, you can appeal to the Special Appeal Committee and then to the High Court.

b) The SANC

The South African Nursing Council sets and maintains standards of nursing education and practice in South Africa. The SANC is committed to quality in health care by safeguarding standards of education and practice of nurses, midwives and support staff so that the South African public receives a competent, safe, compassionate and ethical health service within the framework of comprehensive health care.

The SANC aims to:

- Promote the health standards of all in South Africa.
- Control the education and training of registered nurses, midwives and enrolled nurses.
- Advise the Minister of Health on any issues in the *Nursing Act 50 of 1978*, and on amendments to the Nursing Act.
- Communicate important information to the Minister of Health arising out of the work of the SANC.

8.6.5 Litigating to claim health rights

See the examples of court cases on pages 281, 286, 288, 289, 291, 292, 295 and 296.

For more on advancing rights through the courts, see Chapter 2 from page 71 onwards.

There are a number of examples in this chapter of how the courts can protect people's health rights.

Although court cases are expensive, there are organisations such as the Legal Resources Centre (LRC) and the Women's Legal Centre that are funded to assist you in taking public interest health cases to court.

If you want to complain about unfair discrimination in health services, you can contact the SAHRC for assistance.

Discussion ideas

TALKING POINT 1

Gracie, a 32-year old working woman, is not feeling well and decides to visit Dr Laskin, her general practitioner, for a medical check-up. Dr Laskin starts fondling Gracie and later rapes her. Gracie is devastated and traumatised. She decides that the best way to do something is to have Dr Laskin reported, but she has no idea how to go about doing this.

Discuss what options Gracie has to make a complaint against Dr Laskin, and then advise Gracie on:

1. *Who can the complaint be made to?*
2. *How must she make the complaint?*
3. *What details must she include in the complaint?*
4. *Which organisation can help her?*
5. *How can she appeal if her complaint is not successful?*

TALKING POINT 2

Ms Khumalo has recently been diagnosed with breast cancer. Dr Naidoo at the Tygerberg Hospital (a State hospital) tells her that she needs chemotherapy to make sure that the cancer does not spread. Ms Khumalo is a domestic worker and earns a salary of R500 a month, does not have medical aid and cannot afford to pay for chemotherapy. She asks Dr Naidoo if she can provide her

with the treatment at Tygerberg Hospital free of charge. Dr Naidoo says that the hospital does not have the money for this – so, unless Ms Khumalo can afford to pay for the treatment, they will not be able to provide her with treatment.

Discuss these questions:

1. *Who should be asked to explain and account for the hospital's decision? Is there anyone besides Dr Naidoo?*
2. *What questions should the relevant doctors be asked to make sure they are making a fair decision that respects Ms Khumalo's rights?*
3. *What other alternatives can the hospital consider to meet Ms Khumalo's needs?*

Now divide into two groups to discuss these tasks:

Group 1: Advise Ms Khumalo on the possible constitutional rights and arguments she can use to challenge the hospital's refusal to provide her with the necessary treatment.

Group 2: Advise the hospital on whether chemotherapy can be considered "emergency medical treatment". If not, can Ms Khumalo's claim be made under section 27(1)(a) of the Constitution?

TALKING POINT 3

Donovan Solomons is a student at a local university. Feeling ill, he goes to the local clinic where the doctor told him that he "was probably infected with HIV". The doctor then took his blood and told him to come back in a week. At the next appointment, the doctor told him that his blood was tested for HIV and that he was indeed HIV positive. Donovan is very upset and storms out of the clinic. At home his girlfriend, Theresa, is concerned, but because he is scared he does not tell her. He regularly has sex with Theresa without a condom.

To deal with the trauma of finding out his HIV status, Donovan goes for student counselling about HIV, and his health and lifestyle choices. He is also counselled about the need to wear a condom when he has sex with Theresa. However, Donovan tells the counsellor that he does not like having sex with a condom and that he "cannot wear a condom now in any case because Theresa will be suspicious". He thinks she will know that he is living with HIV and will leave him.

The counsellor now contacts Theresa to tell her that Donovan is HIV positive. Theresa leaves Donovan. Donovan now wants to know to what extent his rights have been violated.

Discuss these questions:

1. *Did the doctor at the clinic act in an appropriate manner? Is there anything Donovan can do about the way the doctor behaved?*
2. *Did the counsellor at the university act in an appropriate manner? Is there anything Donovan can do about the way the counsellor behaved?*

References and resource materials

Constitution, legislation and policy documents

Children's Act 38 of 2005.

Choice on Termination of Pregnancy Act 92 of 1996.

Constitution of the Republic of South Africa, Act 108 of 1996.

Correctional Services Act 111 of 1998.

Department of Health: Patients' Rights Charter, 1999.

Department of Health: Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment, 2003.

Draft Health Charter, June 2006

Medicines and Related Substances Control Amendment Act 90 of 1997.

Medical Schemes Act 131 of 1998.

Mental Health Care Act 17 of 2002.

National Health Act 61 of 2003.

Nursing Act 50 of 1978.

Promotion of Administrative Justice Act 2 of 2000.

Regulations relating to a transparent pricing system for medicines, Government Gazette No. 26304, 30 April 2004.

Regulations relating to the suspension of practitioners, Government Gazette 449, No. 23998, 1 November 2002.

South African Medical and Dental Council's Ethical Guidelines on HIV/AIDS, 1995.

State Liability Act 20 of 1957.

Sterilisation Act 44 of 1998.

Tobacco Products Control Amendment Act 12 of 1999.

White Paper on the Transformation of the Health System in South Africa, 1997.

Cases

B v Minister of Correctional Services 1997 (6) BCLR 789 (C).

Christian Lawyers Association of SA v Minister of Health 1998 (4) SA 1113 (T).

Christian Lawyers Association of SA v Minister of Health 2004 4 [All] SA 31 (T).

EN and Others v The Government of South Africa and Others, Durban High Court, Case no. 4576/2006 (unreported)

Hoffman v South African Airways 2001 (1) SA 1 (CC).

Jansen van Vuuren and Another v Kruger 1993 (4) SA 842 (A).

Minister of Health and Others v Treatment Action Campaign and Others 2002 (10) BCLR 1033 (CC).

Minister of Health and Another v New Clicks and Others 2006 (1) BCLR 1 (CC).

Soobramoney v Minister of Health, KwaZulu-Natal 1997 (12) BCLR 1696 (CC).

Stoffberg v Elliot 1923 CPD 148.

Van Biljon and Others v Minister of Correctional Services, 1997 (4) SA 441 (C).

International documents

Beijing Declaration and Platform for Action, September 1995.

CEDAW Committee, General Comment No. 14 (9th session, 1990), UN doc. A/45/38 at 80 (1990), Female circumcision.

CEDAW Committee, General Comment No. 24, Women and health, 20th Session 1999 UN doc. A/54/38/ at 1(1999).

CESCR, General Comment No. 14 (22nd session, 2000), UN doc. E/C. 12/2000/4, The Right to the Highest Attainable Standard of Health (art. 12 of the ICESCR).

CRC Committee, General Comment No. 3 (32nd session, 2003), UN doc. CRC/GC/2003/3 (2003), HIV/AIDS and the rights of the child.

CRC Committee, General Comment No. 4, (33rd session, 2003), UN doc. CRC/GC/2003/4 (2003), Adolescent health and development in the context of the Convention on the Rights of the Child.

Convention on the Elimination of All Forms of Discrimination Against Women, 1979.

International Covenant on Economic, Social and Cultural Rights, 1966.

Publications

Baldwin-Ragaven L, de Gruchy J and London L,1999, *An Ambulance of the Wrong Colour*, Cape Town: University of Gape Town Press.

Bilchitz D, 2005, Health, in Chaskalson and others (eds), *Constitutional Law of South Africa*, 2nd edition.

Chapman A and Rubenstein L, 1998, *Health and Human Rights: The Legacy of Apartheid* American Association for the Advancement of Science.

Chirwa D, 2003, The Right to Health in International Law: Its Implications for the Obligations of State and Non-State Actors in Ensuring Access to Essential Medicine, vol. 19, *SAJHR*, 541–566.

De Vos P, 2003, So Much To Do, So Little done? The Right of Access to Antiretroviral Drugs Post-Grootboom, 7 *Law, Democracy & Development*, 83.

Heywood M, 2003, Contempt or Compliance? The TAC Case after the Constitutional Court Judgment, *ESR Review*, 4(1), 7.

Muntingh L and Mbazira C, 2006, Prisoners' Right of Access to Antiretroviral treatment, *ESR Review,* 7(2), 14–16.

Ngwena C, 2003, Access to Antiretroviral Therapy to Prevent Mother-to-Child Transmission of HIV as a Socio-Economic Right: An Application of Section 27 of the Constitution, *SAPL,* vol. 18, 83.

Pillay K, 2003, Tracking South Africa's Progress on Health Care Rights: Are We Any Closer to Achieving the Goal, 7 *Law, Democracy and Development*, 55.

Sloth-Nielsen J, 2003, Too Little? Too Late? The Implications of the Grootboom Case for State Responses to Child-Headed Households, 7 *Law, Democracy & Development*, 113.

Toebes B, 1999, *The Right to Health as a Human Right in International Law,* (2nd edition), Intersentia-Hart.

Toebes B, 2001, The Right to Health, in Eide and others (eds) *Economic, Social and Cultural Rights,* Kluwer Law International, 169–190.

Van Wyk C, 2003, The Enforcement of the Right of Access to Health Care in the Context of HIV/AIDS and Its Impact on the Separation of Powers, *THRHR*, vol. 66, 389.

Reports, submissions and other resource materials

AIDS Law Project and Lawyers for Human Rights, 1997, *HIV/AIDS and the Law* (A Trainer's Manual).

AIDS Law Project and AIDS Legal Network, 2003 (3rd edition), *HIV/AIDS and the Law* (A Resource Manual), also available on AIDS Legal Network website.

Brümmer W, 2005, 'Daar is tog 'n môre', *Die Burger*, 20 November 2005.

Budlender D, 1998, *The People's Voices,* Report of the National Speak Out on Poverty Hearings, March to June 1998, convened by SANGOCO, CGE and SAHRC (SANGOCO: Johannesburg), 41–45.

Cape Times, 'Abortion staff urged to put duty before beliefs', 5 June 2000.

Liebenberg S and Pillay K, 1998, *Poverty and Human Rights,* Report of the National Speak Out on Poverty Hearings, March to June 1998, convened by SANGOCO, CGE and SAHRC, (SANGOCO: Johannesburg), Chapter 4.

Mbongeni Z, 1999, 'Children lost outside the health grid', *Reconstruct (Sunday Independent),* 12 December 1999, 5.

National Progressive Primary Health Care Network, 1997, *The South African Health Rights Charter: Your Passport to Health Rights*.

Reproductive Rights Alliance, *Barometer:* all editions, quarterly publication.

SAHRC, The Right to Health Care: 5th Economic and Social Rights Report Series, 2002/2003 Financial Year, South African Human Rights Commission, 21 June 2004.

Women's Health Project, *News and Views: Newsletter of the Women's Health Project:* all editions (quarterly publication).

World Health Organisation, 1995, *Achieving Reproductive Health for All: The Role of WHO* (Geneva).

Websites

Aids Legal Network: www.aln.org.za.

Aids Law Project: www.alp.org.za.

Department of Health: www.doh.gov.za.

Health-e: www.health-e.org.za.

South African Human Rights Commission: www.sahrc.org.za.

Treatment Action Campaign: www.tac.org.za.

Treaty Body Database: www.unhchr.ch/tbs/doc.nsf.

World Health Organisation: www.who.org.